ORIGINAL

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

March 17, 2016
11:00 A.M.
James Thompson Training Room
Cabinet for Health & Family Services
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Sharon Branham
CHAIR
(appearing telephonically)

Susan Stewart
Missy Bonsutto
Billie Dyer
Rebecca Cartright
(appearing telephonically)
TAC MEMBERS

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

APPEARANCES
(Continued)

Gregg Station
Erin Varble
Earl Gresham
DIVISION OF COMMUNITY ALTERNATIVES

Pam Smith
Niki Martin
HPE

Stephanie Bates
Robbie Eastham
Alisha Clark
DEPARTMENT FOR MEDICAID SERVICES

Pat Walden
DEPARTMENT FOR COMMUNITY-BASED SERVICES

Pat Russell
WELLCARE

Kathleen Ryan
Nancy Redmon
ANTHEM

Laura Crowder
Sherry Farris
AETNA BETTER HEALTH

Mary Hieatt
HUMANA-CARESOURCE

Jack Bolos
PASSPORT HEALTH PLAN

Joyce Lewis
Darlene Litteral
Ryan Osborne
PROFESSIONAL HOME HEALTH CARE

Annette Gervais
EXECUTIVE DIRECTOR
KENTUCKY HOME CARE ASSOCIATION

Appearing Telephonically:

Juan Abreu
HUMANA-CARESOURCE

AGENDA

AGENDA
(Continued)

MS. BRANHAM: Good morning, all, and Happy St. Patrick's Day. I am Sharon Branham, Chair of the Home Health Technical Advisory Council. This meeting is the first meeting we've had November 18, '15, so, we have lots of information to review today.

Let's start out by reviewing the minutes of the 11/18/15 TAC report. And if there are no changes, I will accept a motion to make those minutes part of the permanent record of our Technical Advisory Committee.

MS. CARTRIGHT: If no one has any, I will make a motion.

MS. DYER: I'll second.

MS. BRANHAM: I think the best thing to do is start out with some Old Business that I have in hand here, and it looks like reviewing this, that Old Business is going to fall into some Old Business/New Business because we have some unresolved issues relating to revenue codes, denial of supplies and EPSDT prior authorization.

So, that's where I'm going to start. I'm going to start with approval of EPSDT Special Services. I have in my notes from prior meetings that we were going to have EPSDT that had

the provider number, six months' approval for services due to the fact that we've discussed over and over that these are patients or clients that have very slow movement on improvement with therapy services.

Does anyone know where we stand with receiving EPSDT auth for at least six months with services requested by the medical doctor? And I will direct that to WellCare, any of the MCOs that are there, or if anybody can address that issue specifically.

The reason that it is one of the Old Business that segways into New Business is related to the fact that it's again very time-consuming to continually call to get prior auth for these children who have slow movement on improvement. And we have requested that the MCOs work with us to try to get some kind of standardization so that agencies know what we can request rather than taking our requests and then being denied our request for therapy visits.

And when you speak, just identify yourself so I can take notes for that.

MS. RUSSELL: This Pat Russell with WellCare. As you recall, our authorizations

are based on medical necessity. And if you can demonstrate the medical necessity within that request, you should be getting the time that you're requesting. So, if you're requesting six months and the medical necessity is demonstrated in the authorization request you submitted, you should get the six months.

MS. BRANHAM: And with that being said, Pat, I do know that oftentimes when you request the six months, and we all know that everything we're going to talk about today is related to medical necessity because we don't ask for prior auths if (a) the physician has an order, or, (b) it's not medically necessary.

So, with that being said and assume as we go down the list of issues we're having, a submission for a six-month plan of treatment related to a child with, say, 40 therapy visits, those are being denied.

So, no matter the number that is placed in six months of requested authorization for visits, those are being denied. They're capping it out anything below 20. And as you know, often these children have at least three visits a week. So, that gets eaten up pretty quick. So, we're not

getting a six-month. We're lucky to get 20 visits authorized on an EPSDT child.

So, what can we do to work together until I bring this to the MAC for their recommendation to be made to the Cabinet on working out an arrangement for medically necessary therapy visits for EPSDT?

MS. RUSSELL: Sharon, for WellCare, if you can give me a couple of examples where you guys have requested 40 visits and we limited it to 20, I will look at those because, as you and I both know, there are no limits on EPSDT services. So, that should not be the case.

MS. BRANHAM: All right. Specifically, and I had copies for everything today, but I had an emergency and I couldn't get there. With that being said, I will be happy to send to you what I have, Pat, but I think we have a couple of members there sitting today that have stated to me that the plan only covers 26 visits per year for WellCare in particular. And, then, of course, with those 26 visits being a cap a year, I think there must be some confusion.

So, it's a significant issue that we need to work to be resolved. Billie, do you

want to share that you know firsthand that these are being denied?

MS. DYER: Yes. We have that issue in our agency across actually the MCO continuum, if you will. I think that what the problem is the plan of care, just like Sharon addressed, is for six months. Those children have a medical necessity that has a huge longevity or they would not be requesting, and the medical necessity is clearly stated.

We go back and forth with that. I know there are other outside of the Kentucky public home health agencies that do see EPSDT Special Services, and at every meeting of that alliance group, we hear the same thing.

So, that means for us, then, that we're just going to be calling you and we're going to spend our staff time to call you again and again when it's not a fix in three months.

I'm sitting beside one of the MCO representatives and I think that that's probably the hard part to understand about most of these children, I would guess 97% of the children that are in the EPSDT Special Services Program have long-term congenital anomalies, longstanding diagnoses that

are not just going to go away. Rarely do you have a child with mild speech delay that might be on service for three months or six months.

The thing about these children is is the progress, just like Sharon said, is very slow. It takes a long time. What we get a lot of times is once a week. Now, sometimes that changes and we get something different.

So, when we sit here and say this to you, I'm not going to tell you that it's always a consistent pattern, but it seems like it sort of lines out and then it starts again, but it just causes more work on everybody because the children need it. The doctor says they need it. He approves two times a week and we can get approval for one on a very large basis.

And I have actually some documentation that our EPSDT, really she does more coordination. She's a clerical person but she does an excellent job and she has compiled, Pat, for me several things I will share with you after this meeting and I have some other things.

It's a huge problem and it just spins our wheels. And, then, to get it for more than once a week, there has to be a huge appeal

that a parent or guardian has to do. They have to give approval for the appeal. We have to call therapists back in to do extended kinds of things that most of the time we're now seeing have already been sent.

So, I think Sharon is right in the plea to work together to somehow to come to something so we're not all spinning our wheels and working on the same children over and over when the need is there from the beginning and will be for years to go, else, they will go backwards and cost a lot more money.

Sharon, is that what you're asking me?

MS. BRANHAM: That's exactly. And as I said, there are no limits. I spoke with Gregg Stratton earlier today. There are no limits. They're called "soft limits" but there are no limits and it's very frustrating for agencies who usually are the health department-based agencies that provide this service across the state to a large number of children.

And if they don't receive these services, then, we go on the knee jerk reaction rather than being proactive and trying to

continue with their services.

The MCOs are there today, but I would like to say that either we're going to have in writing to the TAC your suggestion how to handle this to decrease the additional work that should not be required for EPSDT Special Services, or I will ask the Medicaid Advisory Council to bring to the attention of the Cabinet and have them be involved and tell you all what to do.

I think it would be better if we could work it out, but it seems like that it's just literally a scattered chart if you were to do an overlay to see who gets approval and who doesn't get approval and how many approvals that you get and then false information that is spread that there is a number of therapy visits that cap out on a year.

So, with that being said, could someone please advise me other than Pat and WellCare who is there?

MS. REDMON: This is Nancy Redmon with Anthem. I don't see any reason why we can't work together. I'm not sure of examples specifically where it's limited in our authorization.

But I did want to bring up,

and bear in mind that our contract also specifies that we cannot duplicate services that are provided in a school setting. So, we would have to ensure in some way that if you're talking about predominantly therapies, we are not duplicating what the child is already receiving in school.

MS. BRANHAM: We don't ask for authorization for those visits in the school system. The school system does that. So, it would appear to me that the Cabinet would identify to you the children through the school districts that are receiving EPSDT Special Services. We're not even addressing that. What we are addressing is what we are doing in the home.

MS. DYER: Just to speak to that, as I understand it, when I talk to therapists or my nursing supervisor speaks to therapists that manages the EPSDT Special Services Program, it's a different focus. It's one-on-one and it's for a longer period of time. The focus different.

Those children in the schools, I don't know anything about that approval. I'm sort of like Sharon. That's theirs to do. We're really from a total medical model based on physicians' orders in EPSDT Special Services, and it really is

to keep the child from going backwards and hopefully improving.

So, I think that that has been maybe a little bit of a misunderstanding because when I talk to the therapists, what they tell me or what they tell Tina is the focus is just not quite the same. And I don't know, Sharon, if you've had that same communication with therapists or not but that's what I hear. It might be one time a week in the schools but they might still need two times a week in the home because it's just different and it does help their progress. If they have Attention Deficit Disorder, they're going to be more involved and engaged in the home.

So, really what we're saying here is advocacy for these patients that really don't have much of a voice and their parents don't always know what avenues to take, and sometimes they will say no to an appeal when we're like please let us appeal this, but it is a lengthy process to ask for a reconsideration or an appeal for everything.

So, I really appreciate you saying that we should be able to work this out, but I think that it is a better understanding of the needs of this patient census or patient population

and what the dire straits that families are in to try to manage children in the home and hopefully get them to improve to a degree that their quality of life or their functions later in life are a lot better because sometimes it takes years to see the improvement that's needed.

So, it's very dear to my heart. You can probably tell that because I've worked with it for a very long time and I just see how much it does help in the long run of things.

MS. BRANHAM: So, the MCOs should have clients identified in their system if they're receiving services through a school system and be able to identify a prior authorization request that comes in from a home health agency following the medical model and physician's order and need established to get those authorizations for visits given.

So, I think this might be where the disconnect is coming from, but we've been on this for over two years and I really need a commitment today from the MCOs and what they're going to do or I have to go forward with it because of the advocacy of the clients and their families and continuing their services.

With that being said, what other MCOs do we have represented that could give us some kind of an update or a quasi commitment as to what they are going to look at to do.

MS. RYAN: This is Kathleen Ryan. I'm with Anthem also and I just want to mention that for prior auth requests for the EPSDT, we do base it on medical necessity and we don't have limits for this population.

MR. ABREU: This is Juan with Humana-CareSource. We also review for medical necessity. We don't have limits on EPSDT, but the only sticking point on EPSDT is whether it has been provided by a participating provider or not.

MS. BRANHAM: Juan, we would not be asking if we didn't have a provider. So, that's all on the side and we all understand that.

What we don't understand is having an EPSDT provider number and serving this special population, why we can't come together with an understanding to have these children served who medically need this service and understand that it's not a duplication of services and that there are no limits.

In the contracts that have

been set forth with the Cabinet, it is my understanding under EPSDT, there are no limits. It follows medical necessity. So, that all is understood.

So, let's get that behind us and say why are we coming up against these issues related to the MCOs when the representatives there tell us the same thing that we talk about - no limits, medically necessary and give examples. We have been doing this. So, now is the time to pull the trigger on this and for you all to tell us what we can do to work this out.

MR. BOLOS: Sharon, this is Jack Bolos with Passport. Our home health services and our therapy services, again, like others, are unlimited. So, EPSDT never comes into play with our home health services. We do do EPSDT with other services that have limits like private-duty nursing, but we don't have any issues with EPSDT at all with home health.

MS. BRANHAM: Thank you. So, I guess, then, Pat, you're on the hot seat for this one. Nancy spoke of duplication of services and Kathleen spoke of no limits and on the medical model.

So, with that being said, I think Billie has examples to give to you, Pat, about the denials and the being told the limit of 26 on visits.

So, what we're going to ask that the MCOs do is put in writing to the Technical Advisory Committee the procedures for having at least a six-month plan of care in place when medically necessary to provide services to for EPSDT.

We know number one would be a provider number. Number two would be the doctor's order stating the medical necessity of this. And number three would be the therapies that you all cover and how often we can cover.

And, then, if we can get that nailed down, we can have it circulated to the home health agencies in the state and then we can resolve this issue because if we don't have it, we're going to have to take it further.

So, are we in agreement that that can be done?

MS. RYAN: Would you mind going over that one more time? What exactly are you wanting in writing?

MS. BRANHAM: We are wanting the managed care organizations to place in writing to the Home Health Technical Advisory Council how we are able to obtain without roadblocks a plan of treatment that last at least six months for a child who is receiving home health services in the home for therapy visits with no limits on the medical model.

And it would be as simple as home health agencies must be an enrolled provider. There must be no duplication of services. You might have a physician's order. You may request therapy visits that are medically necessary according to the assessment of the child and the six-month plan of care.

Give us the steps how to do that and we can review it, and then we can go forward with this being circulated so that we're all on the same page and we're not batting this back and forth.

MS. DYER: Just one thing to add to that. It might be the agreement of people in the room that this is the best way to do that, but sometimes I'm not sure that that gets out to the end when we're on the phone with people.

So, that's the only thing I have to add to that, that this would require consistent education it seems like on our part to our staff and our therapists----

MS. BRANHAM: As well as the MCOs with their CSRs that provide the prior authorizations.

I think our next meeting is scheduled in May. So, really, if we could have this prior to the next meeting because the TAC is prior to the MAC. Maybe we could say something like close of business on "x" day for that to be submitted to Erin who would submit it to me and we'll be ready, then, with any further questions that we can direct at our May meeting. Let's say close of business April 30th.

So, I'm going to call it the model of which to obtain EPSDT Special Services draft document. Any other thoughts, questions, consideration for that?

We're going to move on now to the clarification, the discussion we've had of prior authorizations for visits versus hours and the HCPC code in January, that we should be using the revenue code only under the state health plan, but I'm not

sure that's ironed out entirely. So, if we could have an update on that, that would be helpful.

MS. HIEATT: This is Mary with Humana-CareSource. Juan and I have had several discussions about this. Basically, Juan did a lot of investigation. Our system requires us to enter the auth as hours but everything is paid in visits. The claims are paid as visits.

It's basically a matter of we've always done it this way, but with new staff coming in, when they're giving the authorization, they're giving it in hours instead of visits. The claims have bene paying correctly.

MR. ABREU: Yes, Mary, and I can speak to that. The claims are being paid correctly. It's been our practice all along that we communicate to the providers how many visits were approved.

The breakdown was that we started communicating how many units were approved. That should have never happened. We're correcting that with our team immediately.

MS. BRANHAM: So, that is corrected or you're still waiting to get----

MR. ABREU: As of yesterday, a

communication went out and it's to be fully implemented as of today. And what I would like to encourage is if anybody gets information like this that's been corrected, feel free to reach out to me directly and I will be more than happy to re-educate our team, but, yes, they should never have received a communication that this was in units. They should have received a communication about the number of visits and that is how it is being paid.

MS. BRANHAM: Thank you very much. Circling back around to payment for supplies. We received information that authorization is no longer required. This is on items that are like $250, $500, yet, when the claims are being submitted and sent it - we'll have examples there for you today from Susan Stewart - they are being denied.

So, we don't know exactly how you want this billed. It says we are receiving denials for T Codes that's not being authorized even though the line item is less than the $250 limit to require a prior auth.

Pat, I have one for you or a couple for you. Susan, did you bring copies?

MS. STEWART: I did bring copies I can give her.

MS. BRANHAM: You have those copies, then, and you will see that there is denial even though the line item is less than $250.

MS. RUSSELL: We will review those, Sharon.

MS. BRANHAM: Thank you. The next issue that comes aboard is a patient who is receiving services under a particular MCO and authorization for a plan of treatment which usually is 60 days, and if the patient goes into the second 60-day episode, we always receive an authorization; but somewhere in that 60 days, a patient slips out of that MCO unbeknownst to us, and, then, the agencies are receiving a request that the MCO wants the money back because the patient wasn't covered for one month out of three or four under that MCO because the patient has slipped back to regular Medicaid.

And if they're under an authorization, how are agencies to know that some glitch occurred which flipped that patient to either the state health plan or another MCO. And then we get demand letters - particularly Coventry, this has occurred - so, we get demand letters. So, we don't know how to deal with this.

MS. CROWDER: Make sure they're checking eligibility every month. I mean, that's just it. I came from the other side that you're on and I had to check eligibility monthly on all of our patients.

MS. BRANHAM: We do check monthly.

MS. CARTRIGHT: But it happens in the middle of the month and then you don't know.

MS. BRANHAM: So, if you check April 1st and you provide your services, and at the end of April, the first week of May, you submit your claims for the visits that you have performed under an authorization, they are denied saying that the patient had another MCO or went to the state health plan.

So, how can we deal with this when we don't have any idea why they flipped this month; and if you have approval for the month for "x" number of visits, then, we should be allowed to bill no matter who it is because we have authorization for a visit. So, what we are receiving are demand letters for a payback.

MS. BATES: Eligibility is month pure. So, what you just said is correct, but

I think what she is saying is they go back. It's retro-eligibility is what the problem is and I don't really know. We would have to see examples.

But in the current MCO contracts, when there's a retro-eligibility situation, they're supposed to waive the prior authorization. So, I don't know if you have examples of that that I could see, but there's not really a whole lot. You can get your money from the next MCO when you find out who the MCO is or if it's fee-for-service.

MS. BRANHAM: But we provide the service not knowing. When you get an authorization for visits for a month or two weeks, whatever it may be, then, that's how we work. We have a good-faith effort that we've received this authorizations and we're performing the service.

Then we will and then we're told, sorry, it's denied because April 12th they went with somebody else. So, we get a demand letter. Say it can happen three months down the road and an MCO paid us, as accordingly they should, but then upon their review, I would suppose, they say, oh, you've got to pay this money back because they went somewhere else.

We don't know why they do that or how they do that or where the glitch is but it's causing some anxiety about being able to perform services and then a demand for money which we didn't know they flipped on the 12th of the month to the state health plan or another MCO.

It would appear to me that the state health plan or another MCO, Stephanie, would be able to honor those authorizations and this straightened up.

MS. BATES: They're not going to flip on the 12th of the month, first of all.

MS. BRANHAM: Yes, they do.

MS. CARTRIGHT: Yes, they do, to the state health plan from a managed care, and how does that happen?

MS. BATES: So, provide me with an example of one that flipped on the 12th of the month; but that aside, every single time any provider in the state performs a service, they need to check eligibility the day of the service.

MS. BRANHAM: The day of the service----

MS. CARTRIGHT: We don't have the staffing to continually have to check something

that really you check monthly. You shouldn't have to worry that each time----

MS. BATES: Well, I'm sorry, but you're just going to have to do that. I mean, that's just the way that it is.

MS. BONSUTTO: So, just so I understand, so, you're saying if we have daily care, we should check eligibility every single day even though we got authorization to do that?

MS. BATES: Yes. If you provide a service, then----

MS. BRANHAM: No. No. No. We have authorization. We check that as regularly as we can, and believe you me, as much money as we have lost in this state, Stephanie and to the MCOs, I assure you that we check it as often as humanly possible. We provide that service. We submit bills. We get paid.

Then along comes a letter four, six, eight months later that says, oh, for 20 days, they went to the state health plan, so, you've got to pay us back.

Well, no. That's a software glitch on the Cabinet's side feeding information to the MCOs versus the agency side daily checking

before you walk out the door. That isn't humanly possible.

MS. BATES: I get it, but what I'm saying is I can help with any kind of retro-eligibility situation. I do it all the time and I'm here to help but I need you all to understand for one that it isn't really the MCO's fault. They can't pay for somebody that's not theirs. So, that's why they have to go back and recoup.

MS. BRANHAM: Then, who do we look to be paid for the services that we rendered for two weeks when they went to state health plan before somebody switched them back to the managed care they were before they were two months on our side?

MS. BATES: If you provide a service to me, a therapy service and WellCare comes back and recoups because they find out that they were with Anthem, then you take that recoupment letter and you bill Anthem, and the timely filing starts on the date of that recoupment letter.

MS. RYAN: This is Kathleen from Anthem. I just wanted to mention our continuity of care. If the provider says that this auth was already issued by the previous managed care

organization, then, we will honor that if it overlaps into our eligibility time. So, I think that process resolves the concern.

MS. BATES: And that's in the contract. So, if you all run into a situation where you're denied because of no authorization for some reason when it's a retro-eligibility situation, we need to know about that because the next MCO has to----

MS. BRANHAM: Now, who do we look to, then, Stephanie, if we provided the service under prior authorization for two months, and six months down the road, we receive a letter from the MCO that says, oh, for fourteen days, they were on the state health plan?

The state health plan won't pay us because we didn't get prior auth. Will the state health plan acknowledge those prior authorizations that we have in hand?

MS. BATES: Yes, ma'am.

MS. BRANHAM: Oftentimes, they go to the far side for like two weeks and then they go back to the same MCO that they had their authorizations under.

MS. BATES: I don't really

know what else to say about the situation other than if you run into problems, you can contact me.

MS. BONSUTTO: So, I just want to understand. So, what I hear you saying is if we've got an MCO and then we get a denial letter in the middle of the month and yet we provided services the whole month, we are paying back the MCO.

And then we should take that recoupment letter and we should contact Medicaid and Medicaid should honor that without having to have authorization.

MS. BATES: If fee-for-service Medicaid is who they have, yes.

MS. SMITH: You still have to have the authorization number but you're not going through the review process.

MS. BONSUTTO: How do I get the authorization number because what will happen is they'll say that you're denied because Medicaid didn't authorize it. So, am I supposed to use the Anthem authorization number?

MS. SMITH: Yes. You provide that to Carewise and if there are problems with Carewise, then, either Stephanie can help or we work

those all the time, my staff does at HP. So, yes, we honor that authorization and then we have the copy of the recoupment letter so that timely filing is not an issue because it starts with the date of that recoupment. I did two or three last week.

MS. BRANHAM: The other glitch on this is sometimes we have provided the service under the prior authorization. We have billed for the service, been paid for the service. And, then, four, six months later, we get the recoupment letter. So, should we----

(TELEPHONE SYSTEM NOT WORKING)

MS. DYER: While we're waiting for them to come back up, has anybody researched or maybe you, Stephanie, would be the appropriate person to research how that could even happen. If we could get to the root of that.

MS. BATES: I'm going to be honest with you. I don't know. Specific situations, I wish I knew because I'm tired of dealing with it myself.

MS. DYER: Well, we are, too, because it costs a lot of money to go back and do all that.

MS. BATES: I going to be

honest. It isn't me obviously. It's nobody in this room. Sometimes it's some crazy computer thing. Sometimes it's because they find out a member really wasn't eligible. I don't know. I wish that I knew. Usually, when they kind of stuff happens, that's when you figure out system problems, too.

MS. DYER: And that's what it seems like it is to me, that there's some little something in there that it has to be a system problem because that just wouldn't happen because everybody has always known that it's month by month regardless of whatever to switch it.

MS. BATES: And if you all have one where something switched in the middle of month, then, something is wrong.

MS. DYER: And we have had that. That's what they're saying. They're actual eligibility switches according to the denial that we get.

MS. RUSSELL: Incarceration would be the only one that would be middle of the month.

MS. DYER: This wasn't. It switched to another. I mean, you can imagine their dismay on their end.

MS. RUSSELL: When you guys get that recoupment letter from WellCare or whoever, look at the state file. See who they are assigned to. That's the person you need to bill.

MS. DYER: We already have done that. That's who we would be billing to because I can tell you from our point of view with the number of Medicaid patients that we serve that it takes almost four staff members a solid day one day a month to check eligibility. So, there's no way in the world we could check it every day. There is no way.

MS. BATES: That's just our standard thing, though. We say every time you perform a service----

MS. DYER: And I understand that. You say that standardly, but when they say it's physically impossible, it's financially impossible. Nobody in the world in home health could do it.

MS. BONSUTTO: You can't keep your agency alive. With the little bit of money we get on per visit, there's no way.

MS. BATES: I get it. I understand that. Honestly, even if you did check it

every day, it's not going to help when you get t hose three-month recoupments and those are the big ones. So, that's not going to help you anyway.

MS. DYER: Now, we haven't seen it lately but it seems like there's some agencies that it happens more in for some reason. It's like that unspoken rule, if it happens once to you, it's going to happen multiple times. It must be an IT thing or something.

MS. HIEATT: We don't know when then switch either. We get a call from an agency saying they're not covered and that may be when we find out they're not covered.

MS. BATES: And the MCO has to take the money back. I mean, they have to. That's just the way it is.

(TELEPHONE SERVICE NOW WORKING)

MS. BRANHAM: Just to wrap this up directing it to Stephanie, when agencies are functioning under a legal prior authorization and providing services and then a random letter comes that states that they weren't covered and when we look that up, we'll find up eighteen days or twelve days or whatever, that we can (a) contact you and let you know what has occurred and provide to you

the demand letter and the MCO authorization letter and number and we'll be paid for those visits, and then we can repay the MCOs?

MS. BATES: If you run into any problems, just let me know and we'll work it out.

MS. BRANHAM: Okay. Thank you very much. Have we closed on the issue of therapy evaluations and the fact that an authorization for an evaluation goes and we don't know what the request for visits is going to be until we do this evaluation? Has that been taken care of?

MS. BONSUTTO: I haven't had any more problems. I checked back and I haven't heard of anybody else. So, maybe it was just a glitch, and I reported that at the last meeting we had, whenever that was at the end of the year.

MS. BRANHAM: All right. Let's touch a little bit on Medicaid provider numbers, agencies that are seeking provider numbers, particularly for private duty and things like that that from the time you submit a clean application, that it should take no longer than 60 days.

And who do you direct me to tell folks seeking those new provider numbers, who

can you tell me to contact when all the information has been submitted, no further request for information and it's been greater than 60 and you're getting to the 90, 100 days? Who can I tell folks to contact? Does anybody have that information for me?

MR. GRESHAM: This is Earl Gresham. I don't have any specific information for you. It's Program Integrity. Robert Long is the Director but I don't have a phone number to give you right now.

MS. BRANHAM: Okay. That's where we should start?

MR. GRESHAM: Yes. That's the Division that handles----

MS. BRANHAM: I can get the phone number, but that's where we can start?

MR. GRESHAM: Yes. That's the Division that handles the provider enrollment.

MS. BRANHAM: Thank you very much.

Moving along, we still have some murkiness that relate to agencies are having denials of payment for multiple disciplines being provided to one individual patient even with the

prior authorizations.

So, how should we deal with that and why does it occur? For example, it's kind of nonsequential. So, you'll fill the four visits and they will pay two and deny the rest and then you have to do a claim inquiry.

So, what are agencies supposed to do when you bill according to your prior authorization and one travels again to that dark side and we have to go looking for why it was denied when it was authorized and it, like I said, involves multiple disciplines?

MS. RUSSELL: Sharon, this is Pat. Are you talking to WellCare?

MS. BRANHAM: Well, yes, not just specifically, Pat.

MS. RUSSELL: What I will need to see is a couple of those examples, Sharon, because that should not occur. Even if you're doing multiple types of therapies and different disciplines, it shouldn't make any difference if they're authorized. So, I need to understand why you're getting a denial.

MS. BRANHAM: I would suggest and then assume, but we know how assumptions are,

that it's just a human error on processing a claim because if you have auth and you bill according to your auth and when it's randomly kicked out, then, you know, it takes a lot of time, energy and effort to go and search that.

MS. RUSSELL: That doesn't make sense, Sharon.

MS. BRANHAM: It happens with CareSource and WellCare. It runs across the board. So, we're open to suggestions. Every time this occurs, should we send it to the representative for each MCO in trying to get this resolved so they can see on their side what is occurring and then give us feedback?

MS. RUSSELL: From the WellCare standpoint, yes. Send it to us and we will look at it. I can't speak for the other MCOs, but we need to understand why it's occurring. So, if we have a couple of examples, we can investigate that.

MS. BRANHAM: Okay. Thank you much.

This goes a little bit back to denial codes on amount of units exceeding WellCare's fee schedule. I think we talked about this or either I've just looked at it so much, I think I've

talked about it before, but we don't know, for example, if there is an internal limit, particularly if we have received an authorization or if it's under the $250. So, are there limits? Other agencies are changing their bills to record today a unit so they can bill the entire amount, but I'm not sure on billing on these UB 40's we actually report billed units because we're afraid of fraud and issues like that. And we get a denial code IH126 and it will say denied, exceeds maximum number of units. So, we don't know where that is coming from.

MS. RUSSELL: And, Sharon, I talked to Susan before the meeting. And what I'd like to do is get a couple of you three guys together and have a conversation with our Medical Director and our Vice-President of our Health Services' area so we can get a better understanding of how you guys bill and how our limits are set because we do have limits.

MS. BRANHAM: Okay. Thank you, Pat.

MS. RUSSELL: So, if you want to give me two or three names from your organizations, then, we will put that call together.

MS. BRANHAM: That would be

directed at the Alliance, Billie, and I will forward those to you, Billie.

MS. DYER: Okay. I can get that set up. Rebecca, do you do some EPSDT Special Services, too?

MS. CARTRIGHT: Yes.

MS. DYER: Yes, I can get that to you.

MS. RUSSELL: But you want to be on it for just discussing limits in general.

MS. STEWART: If it's a discussion about all my other WellCare issues, yes, I want to be part of it.

MS. DYER: So, how broad are you going here?

MS. RUSSELL: What I wanted to do is just talk limits in general because I know some of you all are getting denials that exceed limits across the board, not just the EPSDT.

MS. STEWART: On my end, it's Caroline Nease and myself.

MS. DYER: It might good for Annette Gervais with Kentucky Home Care to be on that call as well just for informational purposes, if she would like to do that. Annette is present

today.

MS. BRANHAM: You guys are the only folks that have brought that to my attention. So, I would leave it up to you and Annette and some others to get that taken care of and then report back to me.

MS. DYER: Rebecca will need to be on it, too. She has got EPSDT out in Western Kentucky, and Annette has got a couple of other names that we'll get on there and whoever else.

MS. RUSSELL: I'll send out the invite and you all can forward it to whoever you think is appropriate to be on it.

MS. BRANHAM: Circling back around, we were told in early January that Coventry had some unpaid EPSDT patients and that they were paying for those patients because they're included or they weren't in their contract, but we need clarification about exactly where we are in that.

MS. CROWDER: I don't know how to answer that. I would have to go back to the Claims Department and find out what this is about.

MS. BRANHAM: If someone will tell me who that is, I could send this to them.

MS. CROWDER: Why don't you

just send it to Laura Crowder so then I can follow up.

MS. BRANHAM: Okay. And, Erin, can you get me the email address to be sure I have it?

MS. VARBLE: Yes.

MS. BRANHAM: Thank you. Moving along, with prior authorizations, agencies have an ongoing and continuing area of frustration that relates to if the signed orders are sent on this request for signature and that is provided, then it states it was too late, what can we do about this because we go back to we said we were going to send the plan of treatment along with our prior authorization request, and those orders legally do not have to be signed for 21 days in the State of Kentucky.

So, those orders are only going to be signed via a verbal order to the agency from the physician. And MCOs are stating because they are not signed orders, we're not going to get an authorization. And it's things like wounds and blood draw and it delays care being given to the patients.

If every agency submits the

485 which stand as a plan of care with their request for a skilled nursing visit one to two times a week for dressing, physical therapy visit one to two times a week for post-stroke care, blah, blah, blah, that was created because an order was given to an agency.

When that is submitted to the MCOs along with a request for (a) skilled nursing, (b) therapy, (c) wound care, (d) blood draw, and it is basically electronically signed by the nurse that created that plan of treatment, I would think that we could come to an agreement that that's a signed order and a prior authorization should be given and (inaudible) hours for care to be implemented, but we're still seeing hold-back from that.

MS. DYER: Sharon, this is Billie. I don't know if you can hear me or not, but we have not been having any further problems in our agency and I haven't heard any within the public home health agency group that we are having this as a major problem anymore.

I heard of one agency that was having some issues maybe back in January and I think they contacted Coventry and I think that has then since been resolved for us. We're not having a

problem right now at least.

MS. BRANHAM: Okay. I know I personally have had a couple of issues with that. So, that's what I'm trying to understand. If that's all worked out, I'm circling back around to see if that has been resolved.

MS. DYER: Yes. It has been resolved for us.

MS. BRANHAM: As far as we know. Okay.

I'm going back to the supply authorization. We get an authorization asking for a supply authorization, don't really need it, and we receive a letter that says you don't need it, an authorization for supplies under the limit, but, yet, you bill it and you get a denial saying you need an authorization.

And I don't know where the breakdown is coming. And, Pat, I'm going to direct that to you and send this to you and I probably already have. Do you know?

MS. RUSSELL: I don't recall it but I will go back and look, Sharon.

MS. BRANHAM: Okay. I'll forward it back on to you, Pat, but I have specific

examples. Anybody else denied prior authorization required but not obtained? The prior authorizations are not required for anything less than $250. Susan, that relates back to your issue as well, right?

MS. STEWART: I'll give her my examples.

MS. BRANHAM: So, it kind of ties in, Pat, that's what is occurring on a broad spectrum.

MS. RUSSELL: Okay. Thanks. We'll look at it.

MS. BRANHAM: I have really not much else on traditional services, but I have some examples. And, Billie, this is coming from your group, electronic claims are sent; and when we call and check on the denied claim, they said it was sent to them on a HCFA 1500. Pat, do you know about UB's for 1500's?

MS. RUSSELL: Sharon, I really don't know, sorry, because you guys always bill----

MS. BRANHAM: Okay. I'm going to send it to you. Just making it a part of the record, you know, that inevitable denial on your supplies - I mean, I'm just going through the list

of things - denial for supplies for not receiving a prior authorization but one that's not required for under $250. That seems to be a song along the way.

MS. RUSSELL: Okay.

MS. BRANHAM: You're going to get a handful of those.

Now, I'm going to switch to Model Waiver II. We've discussed traditional and we discussed a little bit of EPSDT Special Services. Now we're going to move to Waiver.

Is there anybody in the room that can talk to us about Waiver today?

MR. GRESHAM: Yes, there is.

MS. BRANHAM: Let me back up. There's been some talk on the streets, to put it loosely, in regards to this universal prior authorization form. Does anyone know if that has been created; and if it has been created, then, is it being used by other providers on a trial basis or is it going to roll out, or do you know if we're going to hear about this at the MAC tomorrow or where are we?

MS. BATES: The universal PA form, it's been out since January 1st and all the MCOs have it on their websites. Yes, there are a

lot of providers that are using it.

MS. BRANHAM: Let me just bring this to your attention. There has been no communication sent from the Cabinet that talks about this to any provider in our group. So, I would think that would be something that the Cabinet would like to do is announce that there is a universal form, a copy of the universal prior authorization form and tell providers when they can start using it.

MS. BATES: It only applies to MCO, not fee-for-service. I just want to put that out there before fee-for-service starts getting the form. Did we send anything?

MS. BONSUTTO: I don't remember getting anything.

MS. DYER: We just started hearing from I forget which MCO that they needed that form and then got it and started using it.

MS. BATES: Let me say this, too. On that form, you don't have to use that form. You can still use the other way, however you did it before. That was more of an ask from providers in the community to have a common form. So, you can still use the same way that you were doing it.

MS. BRANHAM: Well, that being said, every time I attend the MAC and then I listen to providers for home health and special services, there's always issues that all MCOs require a different prior authorization form and seeing how this has been in the talk around the MAC for quite some time.

So, if there is a universal form that has been sanctioned by the Cabinet and is usable for all MCOs for providers to either willing use or to have knowledge of, that a communication letter about that would be very helpful to providers.

MS. BATES: I don't know that you're going to get an official letter since it's been implemented already, but I can certainly send something out to you officially myself.

MS. STEWART: Can you send it to her so that she can----

MS. BATES: I'm going to send it to Erin.

MS. BRANHAM: We're excited about it and I think that's a great feat that has been accomplished. We would like to sing its praise and get everybody on board for it, and if you could

send that to me, it would be very, very helpful.

MS. BATES: Sure.

MS. BRANHAM: And it's for the MCOs only, not the state health plan, correct?

MS. BATES: That is correct.

MS. BRANHAM: I guess I'm looking now for some direction on Home- and Community-Based Waiver. Where are we in the process? There was a final rule on the Home- and Community-Based Waiver and agencies scrambled to (a) attend it in person or (b) to attend the webinar, and we thought it was going to be the final rule about the whole waiver process, but it was really mostly dealing with adult day and that wasn't made clear and the questions were related to home health.

So, with that being said, there are issues with the waiver and transitioning old patients into the new portal and the fact that their plans of care that were existing are being denied, and we get a lot of messages back that says that determination has not been met.

And the second part of that is the submission of the MAP 24 and the pro cert from Carewise and the local DCBS offices are not acting timely. And, really, we were working hand-in-hand

with Dale on this and it's kind of gone silent because I know I specifically sent four or five staff to what was termed the final rule but it didn't seem to apply to home health and waiver services.

So, with that being said, where are we? What's going on?

MR. GRESHAM: Well, you mentioned several different things in your question. So, I'm not sure where to start.

MS. BRANHAM: Okay. You can start with the first one on patients that are on service being transitioned through the portal with the signed document in place.

Messages pop up that the determination has not been met, but what does that mean in having these patients that are already existing transitioning and you don't know whether to provide the care or not because it says that determination for their services has not been met? Number one, how should we act on that?

MR. GRESHAM: Do you have some examples you can send me so I can see what is happening?

MS. BRANHAM: Yes. There are

lots of messages that pop up. I can certainly forward that on to you, Earl, so that you can understand.

We don't really know how we are going forward and how to assist individual patients and giving the information to take to DCBS and have them scan in and start the process for them to become waiver or determination to become waiver eligible. It's very lengthy. It at times requires two to three visits because the local DCBS offices don't seem to understand what actually is required, and it really is preventing people from filling those slots which have a lot vacant and getting services.

So, it would really be helpful if agencies knew how to direct clients that medically need this service and how to better interact with local offices so that we can get them all started to receive these services.

MS. STEWART: We're not using the portal. Are we supposed to be using the portal?

MR. GRESHAM: It's requested that you use the portal. You're not required to use the portal until the new regulation----

MS. STEWART: Well, that's all

I need to know - not required.

MR. GRESHAM: April 1st, the new regulation requires you to use the portal.

MS. BRANHAM: I'm sorry. I really can't clearly understand. Erin, can you----

MS. VARBLE: As of right now, you don't have to use the portal; but as of April 1st, the new reg will require you to use the portal.

MS. BRANHAM: Is there a provider letter coming out to us for that?

MS. BONSUTTO: So, what I just heard you say is that there is a requirement that as of April 1st, we have to use the portal and that nothing has come out in writing and it will come out in writing on April 1st that we're required to on April 1st because today if March 17th?

And if it comes to one person in an agency, we have to disseminate it to tons and tons of people, and we're 14 days from the requirement; and unless I'm sitting in this meeting, I wouldn't know that.

MR. GRESHAM: And I didn't mean to imply that it would come out April 1st. It should be coming out very soon.

MS. BONSUTTO: But, still,

you're going to give us less than seven day's notice to notify everybody about that? I mean, today is the 17th if we get it. So, when will that be going out?

MR. GRESHAM: Honestly, I don't know. We haven't created a provider letter yet.

MS. BONSUTTO: So, you really don't have any idea. So, there's a new rule starting April 1st, but, yet, you don't know when we're going to communicate to everybody that that's required?

MR. GRESHAM: That's correct.

MS. BONSUTTO: If at least that's a fact, then, we need to as an association make sure that we communicate to people so that we can have the----

MS. STEWART: Is that a hard date or a soft date?

MR. GRESHAM: It's hard as far as I know. The reason I thought everybody knew about it is that was out for public comment, so, I thought it was understood.

MS. BRANHAM: So, with that being said, some agencies have been using the portal

to get better familiar with it, but it's been a frustrating experience because there are some MAP 24's that have been filed since August 15th with no one being able to assist the agency with the information process to do a follow-up with these patients.

And there are lots of pending issues that relate to discharge planning, for example, from a nursing home and you could submit that MAP 24 and then three weeks later, it shows they're still in the nursing facility.

So, I do know that my staff who have been doing this since the session were told that, from Bobbie, the individual who I understand you most speak with when you call in Model Waiver II requesting services, that requirements were changed, and Bobbie wants to know what exact hours that staff is going to be in the home.

And when we say it varies on different days of the week but the regulation is up to 16 hours, it's been sarcastically said that, well, you need to tell the truth, and she's been somewhat rude. And, really, if these requirements changed that we have to say we're going to be there from 6 to 10:30 on Tuesdays and Wednesdays and from

7 a.m. to 6 p.m. on Monday, Wednesday, Friday, we didn't know that nor was that communicated to us. We know that the regulation is up to 16 hours.

So, is that, indeed, the spoken truth about a change in the requirement to know the exact hours when we are asking for services to be implemented and getting the authorization for it?

MS. SMITH: Sharon, this is Pam. And, so, I just want to make sure that I'm on the same page with you because we have been jumping around quite a bit since we started talking about waiver.

So, now, this concern is specific to Model II, correct? We record 100% of those phone calls and it absolutely is not tolerated for someone to be rude and sarcastic.

If you can give me specific or even general days and times and whatever agency it was that called, I will pull those phone calls and listen to those personally and make sure that Bobbie is counseled because there is no reason for there to be rudeness or for there to be any sarcasm.

The requirements for Model II have not changed. They are the same as they have

been. So, if you can get me that.

MS. BRANHAM: I will get an email out to you later this afternoon or it might possibly be Monday because I don't know where the staff that did it, where she is today, if she's in the field or wherever; but when I call back home, I will get that to you, Pam, because I didn't think it changed.

We can be kind of strong on it, but I don't want patients and families to be frustrated because I've been doing this a long time and there's not many of us Model Waiver II providers in the state anyway. So, I had never been alerted that there was a change and you had to give exact hours you were going to be in the home because it's extremely flexible, so to speak.

MS. STEWART: I have a question. What else is coming out April 1st?

MR. GRESHAM: The HCB regulations.

MS. STEWART: Conflict free?

MS. DYER: Well, are we moving on to Home- and Community-Based? I can speak to the requirements----

MS. BRANHAM: Back to the

Home- and Community-Based, I just want a general idea of where we are.

MS. DYER: Sharon, I was just getting ready to ask the question about all of a sudden we're hearing that this is absolutely mandatory April 1st. While I think we've all heard rumblings and hints to that, we really haven't had an official out to all agencies that that's the case.

I can tell you that the Kentucky Public Home Health Association and people I know outside of that, they're going to have to have training again on the MWMA because once we were told that we did not have to use that in order to move patients through and get them on service, not everybody has used that.

So, I don't think that it is physically possible just like Missy is saying here for us to make this go live April 1st. We're sitting here the 17th and don't even have the regulations----

MS. BRANHAM: I tried to find the information that was going to be given on the final rule workshop that was last month.

MR. GRESHAM: The final rule

doesn't have anything to do with----

MS. DYER: What regulation are you referring to, then? Maybe we're a little confused.

MR. GRESHAM: The HCB regulation to go from HCB I to HCB II with the new services. The regulation goes live April 1st. However, the waiver is not approved from CMS yet and will not go live for a few more months.

MS. DYER: So, I'm not sure I understand what you're saying.

MS. BONSUTTO: So, what changes on April 1st, actually changes? I don't understand.

MS. DYER: HCB I to II. I don't know what that means.

MR. GRESHAM: And regulation goes live that we don't have the ability to follow completely, any of us. Medicaid isn't able to follow it completely because the HCB Waiver is not approved by CMS and we cannot operate. So, I don't know honestly.

MS. BONSUTTO: So, what I'm hearing you say and I just want to make sure because I've got to communicate this is the regulation will

go into effect but there's nothing that we need to do at this time because you all don't even----

MR. GRESHAM: We have to work that out. That's correct.

MS. DYER: So, we're not going to be obligated to go into that new reg when you all don't know what it is and we don't have it and we don't know how to implement it then.

MR. GRESHAM: Right, and, honestly, not something I had considered yet until you all brought it up. We'll discuss it and we'll get out information on how to proceed.

MS. DYER: And there's going to have to be training again. I'm just going to tell you. I think maybe Susan alluded to that a minute ago.

There's more than one agency who, in order to move people into the Home- and Community-Based Waiver, went ahead with the old way because we had a directive from Commissioner Anderson that we could do that. So, we did it so we could get people on service and providing services and not caught up in something that wasn't really working yet.

MR. GRESHAM: There is Web-

based training available. As far as training like we had at the very first where everybody came in to Frankfort and looked at the screen shots and everything, there will not be that, but there are job-based trainings and Web-based training available.

MS. DYER: Do you just go to the MWMA? How do you get to that now?

MR. GRESHAM: Is it on our Web page?

MR. STRATTON: I'll send it to Erin and have Erin send it out to the group.

MS. DYER: That would be good, and I have to add to that. Has it been updated because we did get the email how many weeks ago now that said there were problems. Something was transferring to another system.

I don't think I really understood all of that, but, anyway, is this going to be the training that was put out initially or is it going to be updated training for current?

MR. GRESHAM: These job aids have been completed since that training.

MS. DYER: They have been completed since that training.

MR. GRESHAM: Yes, since the initial training way back, December of 2014.

MS. DYER: So, the expectation for all of your Home- and Community-Based Waiver patients to be uploaded in the MWMA is when? You don't know that yet.

MR. GRESHAM: We will let you know.

MS. BONSUTTO: But we do have to go to the portal as of April 1st. That's a drop-dead date. That's what I heard you say earlier.

MR. GRESHAM: Yeah, and I'm going to retract it, but you need to start playing with it because it is coming.

MS. BONSUTTO: I was going to say, I just sent out an email that you said that. So, now I've got to go retract my email.

MS. DYER: Because he just said something different.

MR. GRESHAM: The more people that can use it now, the better off you're going to be in the future as opposed to a drop-dead date when everybody starts trying to use it. ABI has been using it now since--their regulation went live which was February 1st or somewhere around there.

MR. STRATTON: Model II was the same date. So, it's already enacted for Model II.

MS. DYER: What about Home- and Community-Based?

MR. GRESHAM: That's what we're talking about now.

MS. DYER: You're saying I and II then. You're saying I and II, not just Model II, right?

MR. STRATTON: It will be all Home- and Community-Based Waiver.

MS. STEWART: Beginning April 1st, are the UK nurses going to start doing the avows?

MR. GRESHAM: No. I'm sorry. I have confused everybody and I sincerely apologize. We'll get back to you.

MS. STEWART: So, we don't change anything.

MR. GRESHAM: You all treat business as usual.

MS. STEWART: So, what we leave here with today is we need to start using the portal.

MR. GRESHAM: You need to start becoming familiar with the portal because it's coming.

MS. DYER: So, when that communication comes out, specifically do you know how that will be rolled out or to whom? Is there some point person that will get that communication to get it out because we've had that issue in the past that we don't consistently get that communication or one person thinks they've got it. Could Kentucky Home Care Association be a point person to make sure that gets out or what could we do?

MR. GRESHAM: What we will do is we will send it to all the HCB providers.

MS. BONSUTTO: Could you add maybe the Home Care Association to that so that they have that and they can help support the agencies? That might be a good idea.

MR. GRESHAM: I think we send it to the various agencies as well but definitely the providers.

MS. DYER: Annette Gervais that's here with Kentucky Home Care could certainly----

MS. BRANHAM: I am so sorry.

MS. DYER: She could provide you the email. If Kentucky Home Care can get it, too, and push it out, then, that will make sure. Sharon is going to back up and introduce Annette, I think.

MS. BRANHAM: I'm going to save it for the end because I've already messed up because we had technical difficulties and I've got technical difficulties in my brain.

Any other issues that need to be brought to the attention of the TAC before I ask for a couple of things that they can do for us that I have not addressed? I think I hit even some of the late requests that came forward after we did the agenda.

MS. VARBLE: There were three that I added on yesterday I think that came in on an email. I thought you were actually going to be here in person, Sharon, so, I don't think I sent them to you.

MS. BRANHAM: I did, too.

MS. STEWART: Can we get a current list of the MCO liaisons?

MS. BRANHAM: That's my next

thing. We would like to have an updated list of the MCO liaisons and their phone numbers and email addresses, as well as the management structure for the Division of Program Integrity.

MS. BONSUTTO: And another request before we leave is maybe to verify the dates for the other TAC meetings because I know there was a lot of conversation about when the dates were going to be which are different than what was in the minutes in November, I think. We should probably put those in the record.

MS. VARBLE: I've distributed all of my copies of my minutes here. January and March I know changed because the dates of the MAC changed.

MS. BRANHAM: The next one I have down is the 25th of May.

MS. VARBLE: The May date changed. There were a bunch of the Home Health ones that changed.

MS. BRANHAM: May changed because of our conference.

MS. VARBLE: The ones that are on the meeting invite should be the correct days.

MS. BRANHAM: I have 27th, 21

September, 16 November.

MS. BONSUTTO: November 16th is our fall conference.

MS. BRANHAM: That prior week is our conference.

Any other business to be brought before the TAC today? Well, I guess everybody take a big deep breath then.

MS. VARBLE: Hold on just a second because there were some that were sent in by Darlene Litteral and I don't think they're on your agenda, the one I sent you, Sharon.

MS. BRANHAM: I didn't get it.

MS. VARBLE: No, because I sent yours on Monday and these came in yesterday.

MS. BRANHAM: I looked at the agenda that you sent this morning, Erin.

MS. VARBLE: I sent out another updated invite and it just had these in the body of the invite. I didn't actually put them on the agenda but I did it right before I printed them out to come down here so everybody would have a copy because I thought you were here.

One of them was our billing staff has informed us that Passport has recently

instituted a new requirement for billing enteral claims. They are now requiring that the National Drug Code be added to the claim submitted, otherwise the supply is denied payment saying no PA is on file. There is a PA on file and the representative acknowledges such, they reply that the NDC number did not accompany the claim...there is no place on the claim to add an NDC, and what is the purpose of this additional burden that has been created for agencies?

MS. BONSUTTO: Isn't that you, Jack?

MR. BOLOS: I will have to check on that. I'll get back on that.

MS. VARBLE: So, that will be a take-back.

MS. BONSUTTO: Will that come back up on Old Business, then, next time? Is that will happen?

MS. VARBLE: Yes.

MR. BOLOS: Who do I follow up with on this?

MS. BRANHAM: If you can answer me, Jack, and Erin.

MR. BOLOS: I'll get that to

you within the next week or so.

MS. VARBLE: And, then, in the last month, Passport has denied all claims stating that the reason for the denial was no PA found on file. However, PA's are on file. When discussing this with a Passport representative, it was relayed that Passport has loaded "S" codes for visits and not the traditional "G" codes. The agency has not received any communication regarding the change in "G" code billing of claims.

MR. BOLOS: I'll follow up on all that.

MS. BATES: I have an update on that that I will send you.

MS. VARBLE: Okay. During the PA request process, Carewise continues to routinely ask whether the patient is receiving services under the Waiver Program and why are the home health aide services not provided exclusively under the Waiver Program.

MS. SMITH: We've redone education. We had some new reviewers, and, so, this has been addressed, that that question should not be asked because, in fact, the services should come through State Plan first anyways prior to waiver.

So, that was addressed at the end of last week.

MS. VARBLE: We note that other agencies are having grave difficulties with their DCBS and we chime in that our agency is experiencing excessive delays in receive of 552's. The MAP-24 has been faxed multiple times to the local DCBS office and also to the Frankfort office. One particular patient has been waiting on the receipt of a 552 since November of 2015. Why are these delays occurring and is there anything the agency can do to assist in getting timely responses?

MS. WALDEN: This is Pat Walden with DCBS. To determine why the delays are occurring, we would probably need an individual case number to determine why that specific delay is occurring.

We're experiencing the same issues that everybody else does, I assume, short-staffed. We've had quite a bit of turnover in staff since the Affordable Care Act was implemented. So, we have a whole lot of new staff.

Again, why any one case might be delayed we would need to look at that particular case. It might be delayed because of the review of the resources. Perhaps somebody has a trust and

it's with LOS being reviewed. November is a very long time, so, whoever sent that in, if they can send me the case number from November.

As far as the receipt of MAP 24's, we can only use MAP 24's to let us know that somebody has come back from a nursing facility. Otherwise, we must have the pro cert from Carewise in order to initiate an application or a change.

MS. LITTERAL: This particular patient did come from a nursing facility.

MS. WALDEN: Okay. If you can send it to me. I'm Patricia Walden. patricia.walden@ky.gov.

And I will tell you a little disclosure. I'm behind on everything. So, if I don't answer you, feel free to send it to me again. You can send it to me everyday. If I'm sitting there when the email comes through on my email, I may catch it, but I get about 150 emails a day and I'm in meetings about seven hours a day right now.

We have implemented our new system. We are working through some glitches, of course, right now, tweaking and all of that good stuff, but we do hope that the Medicaid Waiver Management application and the levels of care are

coming to us in an interface now. So, hopefully those things will get much better in time.

MS. BRANHAM: Anything else on that, Erin?

MS. VARBLE: No. That was the last one.

MS. BRANHAM: Okay. I must apologize, but I failed to introduce the Kentucky Home Care Association new Executive Director, and she is sitting there today and her name is Annette Gervais, and she has been with us in another capacity for nearly a year, I think, in May.

So, Annette will be your go-to for the association and following information and we're very excited about having Annette as our Executive Director. She has just been a pleasure to work with and I think everyone in the room will find that.

And without further ado, I introduce Annette.

MS. GERVAIS: Thank you, Sharon. Hello, everyone. I've been to a couple of these meetings before. Sharon, I have to correct you. It's going on one year. Tomorrow is my anniversary date that I've been with the

association, and I was at a couple of meetings last year. So, I'm just trying to pick up. I really would like to have all the contact information from everyone. That would be great if you could supply that for me and that way I'm able to communicate with our members with all of the latest issues and concerns.

MS. RUSSELL: Erin, can you supply her contact to all of us as well, please?

MS. VARBLE: Yes.

MS. BRANHAM: Without further ado, I will entertain a motion to close our meeting and a second and everybody can be on their way. Thank you all so much for coming today and participating and working with our technical difficulties.

MS. BONSUTTO: So moved.

MS. DYER: Second.

MEETING ADJOURNED